

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1633

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01665

## CERTIFICATE OF DEATH

Reg. Dist. No. 190

1. PLACE OF DEATH COUNTY <i>Howard</i>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>Md</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Elmridge Park</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Elmridge Park</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Hillside Rd. Box 222</i>		STREET ADDRESS <i>Box 222 Hillside Rd.</i>	
3. NAME OF DECEASED (Type or Print) <i>Mary Edna Bealmore</i>		4. DATE OF DEATH <i>Feb 4 1955</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <i>Married</i>	8. DATE OF BIRTH <i>Jan 4 1893</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i>	
13. FATHER'S NAME <i>Leviatus Cole</i>		14. MOTHER'S MAIDEN NAME <i>Mary Edna Miller</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>ms ms</i>	
17. INFORMANT AND ADDRESS <i>Box 2294 Mrs Ruth Struck Elmridge 27 Md</i>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
<p><i>15-X</i>  <b>Immediate cause</b> (a) <i>Carcinoma of Rectum Dec 194</i></p> <p><b>Antecedent cause(s)</b>            Diseases or conditions, if any, giving rise to the above cause            stating the underlying cause last (b) <i>Several Carcinomata 6 mo</i></p> <p>(c) <i>Secondary Anemia &amp; Hemorrhage</i></p>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <i>Oct 1954</i> to <i>Feb 4, 1955</i> , that I last saw the deceased alive on <i>Feb 4, 1955</i> , and that death occurred at <i>11:20 a.m.</i> from the causes and on the date stated above.			
SIGNATURE		(Degree or title) ADDRESS DATE SIGNED	
23. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>		DATE THEREOF <i>Feb 7 1955</i>	
DATE REC'D BY LOCAL REG. # <i>Feb 7 55</i>		NAME OF CEMETERY OR CREMATORIAL <i>Woodlawn Cemetery</i>	
		LOCATION (City, town, or county) (State) <i>Maryland</i>	
REGISTRAR'S SIGNATURE <i>E. Bird Williams</i>		24. FUNERAL DIRECTOR ADDRESS	

RECEIVED  
FEB 10 1955

BUREAU Y. S.

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

01666

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 191

Item 2, File #177 2-25-55 et  
1684

1. PLACE OF DEATH. COUNTY		Howard MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED. STATE		Maryland COUNTY		Frederick	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN		Baltimore Middletown 10x2	
TOWN		Ellicott City		STREET ADDRESS				(If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		Highland Manor		Montgomery Hosp. R.F.D.					
3. NAME OF DECEASED (First) (Type or Print)		(Middle)		(Last)		4. DATE OF DEATH		(Month) (Day) (Year)	
EDNA J. BUCHANAN						February 12, 1954			
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)		8. DATE OF BIRTH		9. AGE last birthday	
Female		White		Widow		Jany 7 1875		80 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Housewife		Own Home		Broad Run Md.		USA			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME							
John H. Grove		Laura V. Rudy							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT					
No		None		Miss Effie C. Grove					

### 18. MEDICAL CERTIFICATION

#### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

421.4  
Immediate cause

(a)

#### Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

Chronic valvular heart disease c-  
decompensatio-

INTERVAL BETWEEN  
ONSET AND DEATH

6 months

#### II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

#### 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes  No

21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, of office bldg., etc.) INJURY		(CITY OR TOWN)		(COUNTY)		(STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work m. Not White At work <input type="checkbox"/>		HOW DID INJURY OCCUR?					

22. I hereby certify that I attended the deceased from Oct 1, 1954, to Feb 12, 1955, that I last saw the deceased

alive on Feb 17, 1955, and that death occurred at 10:15 a.m., from the causes and on the date stated above.  
Degree or title ADDRESS DATE SIGNED

SIGNATURE

Elizabeth and York 1955

23. BURIAL, CREMATION REMOVAL (Specify)		DATE		NAME OF CEMETERY OR CREMATORIUM		LOCATION (City, town, or county)		(State)	
Burial		3/15/55		Rose Hill Cemetery		Hagerstown Md.			
DATE REC'D BY LOCAL REG.		REG.		REGISTER'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
Feb 15, 1955		John B. Loughran				Andrew K. Coffman		Hagerstown Md.	
Feb. 17, 1955		Per. B. E. L.							

BUREAU V. 8

FEB 23 1955

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH

1685

2411 N. Charles Street, Baltimore

01667

## CERTIFICATE OF DEATH

Reg. Dist. No. 190

1. PLACE OF DEATH COUNTY <i>Fairfax</i>			2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>Md</i>						
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <i>Elkridge</i>			CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Elkridge (Rural)</i>						
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Hanwood Park</i>			STREET ADDRESS <i>Hanwood (Rural, give location)</i>						
BIRTH DATE <i>Mar 09 2019</i>			DEATH DATE <i>Mar 09 2019</i>						
3. NAME OF DECEASED (Type or Print)	(First) <i>Yannie</i>	(Middle) <i>Catherine</i>	(Last) <i>Cooper</i>	4. DATE OF DEATH	(Month) <i>Feb</i>	(Day) <i>21</i>	(Year) <i>1973</i>		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>married</i>	8. DATE OF BIRTH <i>Nov 27, 1943</i>	9. AGE last birthday yrs. <i>61</i>	If under 1 year Months <i>0</i>	If under 24 hrs. Days <i>0</i>	If under 24 hrs. Hours <i>0</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i>	11. BIRTHPLACE (State or foreign country) <i>Harrisburg Pa</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>				
13. FATHER'S NAME <i>Stanley Stonebifer</i>			14. MOTHER'S MAIDEN NAME <i>Hilda Bridal</i>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>			16. SOCIAL SECURITY NO. <i>none</i>	17. INFORMANT AND ADDRESS <i>Mar 20 1973 London Ave Mrs Joseph Cooper Elkridge 27 Mar</i>					
18. MEDICAL CERTIFICATION									

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

<i>260X</i>	Immediate cause <i>Chronic myocarditis &amp; decompensation</i>	INTERVAL BETWEEN ONSET AND DEATH <i>2 mos</i>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) <i>Diabetes mellitus</i>	<i>10 yrs.</i>
	(c) <i>General Arterio sclerosis</i>	<i>10 yrs.</i>

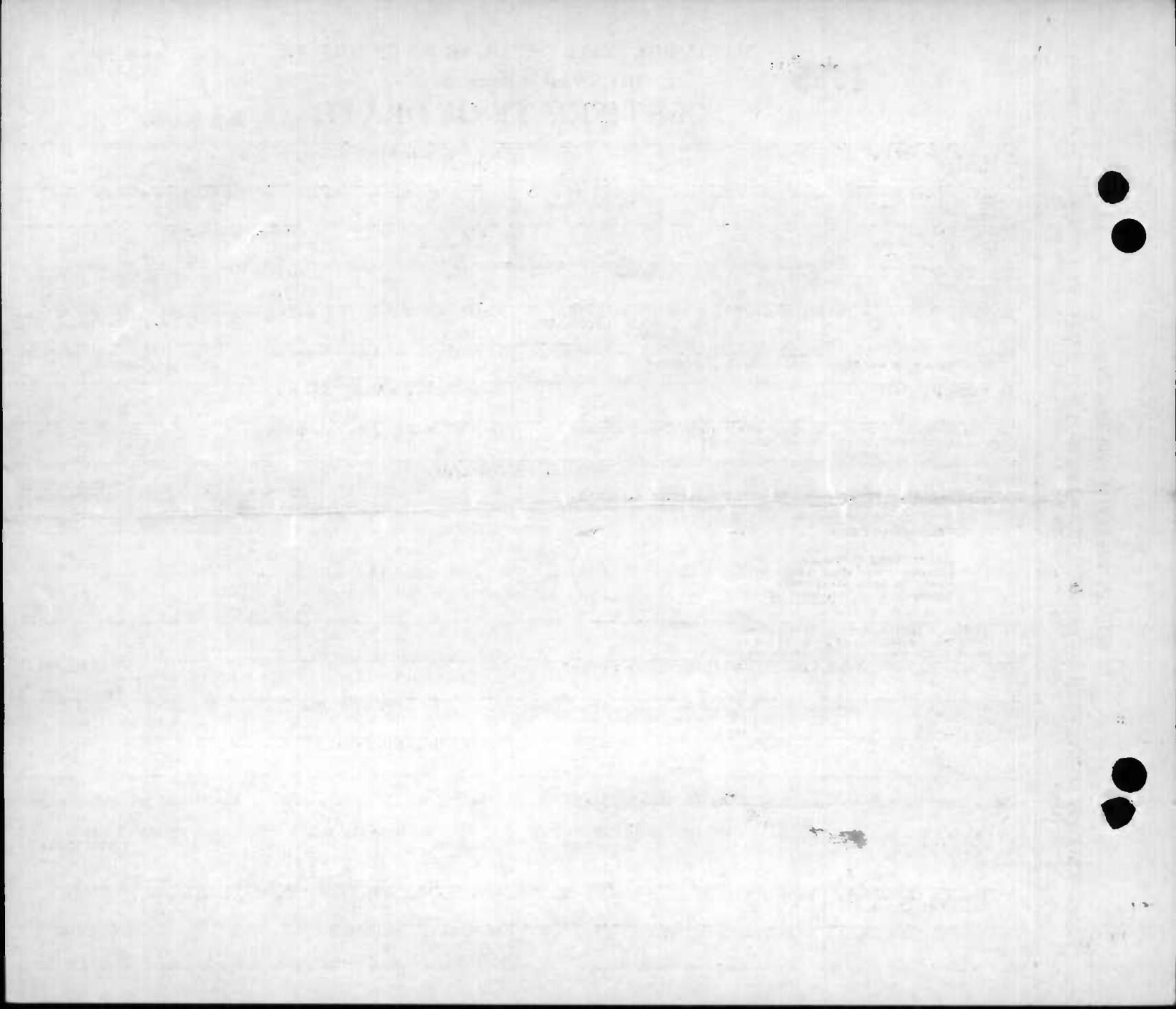
## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not  
related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?			

22. I hereby certify that I attended the deceased from *Jan 1, 1955*, to *Feb 21 1973*, that I last saw the deceased  
alive on *Feb 21, 1973*, and that death occurred at *10:30* m., from the causes and on the date stated above.  
SIGNATURE *[Signature]* ADDRESS *[Address]* DATE SIGNED *[Date]*

23. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>	DATE THEREOF <i>Feb 24, 1973</i>	NAME OF CEMETERY OR CREMATORIAL <i>Baust Cemetery</i>	LOCATION (City, town, or county) (State) <i>Union Bridge, Md.</i>
DATE REC'D BY LOCAL REG. <i>223-55</i>	REGISTRAR'S SIGNATURE <i>Rev. G. J. [Signature]</i>	24. FUNERAL DIRECTOR ADDRESS <i>Henry W. Jenkins &amp; Son Inc. 4905 York Road, Balto. Md.</i>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1686

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

01668

## 1. PLACE OF DEATH:

COUNTY Howard MARYLAND  
 CITY (If outside corporate limits, write RURAL  
OR and give nearest town)  
 TOWN X Ellicott City LENGTH OF STAY  
 (in this place)

HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS 90 Highland Manor

3. NAME OF DECEASED: (First) Lauran (Middle)  (Last) Dorman

5. SEX: Male 6. COLOR OR RACE: white 7. SINGLE, MARRIED,  
WIDOWED, DIVORCED.  
(Specify) Widowed 8. DATE OF BIRTH: Dec. 14, 1870 9. AGE last birthday 84  
yrs.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret.-Book Salesman 10B. KIND OF BUSINESS  
OR INDUSTRY:

## 13. FATHER'S NAME:

John Dorman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No

16. SOCIAL SECURITY NO. - - -

18. MEDICAL CERTIFICATION  
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

450.0

IMMEDIATE CAUSE

ANTECEDENT CAUSE (S):

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE  
STATING UNDERLYING CAUSE LAST.

(A) DUE TO arteriosclerosis, generalized; Senility; Urinary tract infection. 20. INTERVAL BETWEEN  
ONSET AND DEATH 2-3 years

(B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH.

## 19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?  
YES  NO

21A. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory,  
street, office bldg., etc.)

21C. WHERE DID (City or town)  
INJURY OCCUR?

(County) (State)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

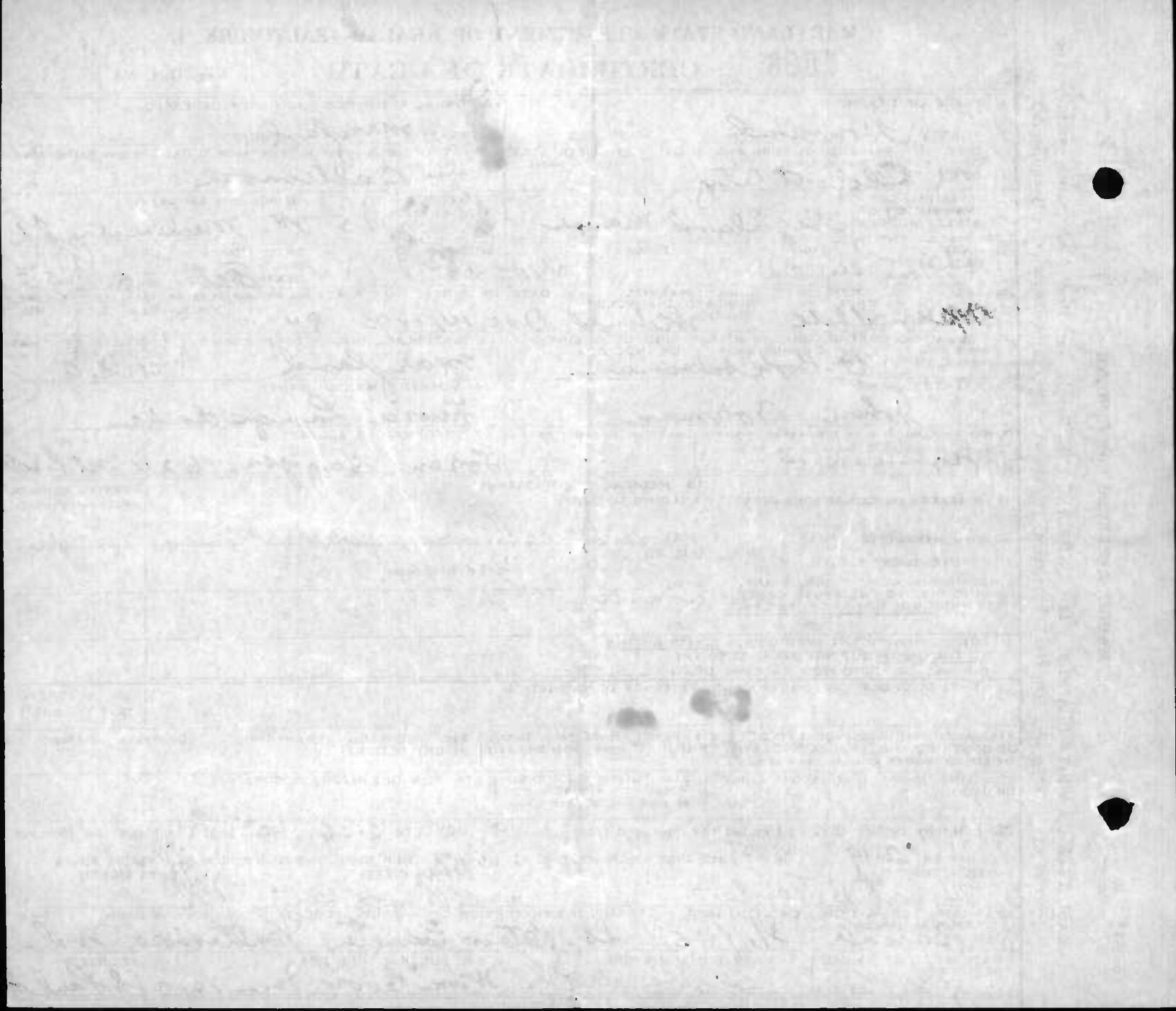
21E. INJURY OCCURRED  
While  Not while   
at work  at work

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-19, 1955 to 2-26, 1955 that I last saw the deceased alive on 2-19, 1955, and that death occurred at 6:45 PM from the causes and on the date stated above.  
SIGNATURE Robert B. Taylor ADDRESS  DATE SIGNED

23. BURIAL, CREMATION, DATE THEREOF NAME OF CEMETERY OR CREMATORIAL LOCATION (City, town, or county) (State)  
REMOVAL (SPECIFY) Burial 3-1-55 St. Peter's Cemetery Baltimore, Md.

DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR ADDRESS  
REGISTRAR 2/28/55 Wm Cook 217 8th Paul St



1687

## CERTIFICATE OF DEATH

Reg. Dist. No. 19/.....

## 1. PLACE OF DEATH:

COUNTY Havre de Grace MARYLAND  
 CITY (If outside corporate limits, write RURAL or and give nearest town)  
 TOWN Ellicott City

HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS  
90 Highland Manor

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Anne Arundel COUNTY  
 CITY (If outside corporate limits, write RURAL and give nearest town)  
 TOWN Annapolis  
 STREET ADDRESS  
02-10-2

3. NAME OF  
DECEASED:  
(Type or Print)(First) EDITH(Middle) N.(Last) JOHNSONAnnapolis

(If rural give location)

4. DATE  
OF  
DEATH:

(Month) Feb (Day) 17 (Year) 1955

IF UNDER 1 YEAR  
Months 76 Days 0 Hours 0 Min. 0

## 10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired

## 10b. KIND OF BUSINESS OR INDUSTRY:

## 11. BIRTHPLACE (State or foreign country):

## 12. CITIZEN OF WHAT COUNTRY?

## 13. FATHER'S NAME:

Edward Rogers

## 14. MOTHER'S MAIDEN NAME:

UnkU.S.A.

## 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

## 16. SOCIAL SECURITY NO.:

## 17. INFORMANT &amp; ADDRESS:

Mrs. Marrie Kleeman Glen Burnie, Md.Interval Between  
Onset And Death2 days10 days

## 18. MEDICAL CERTIFICATION

## 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

443X  
Immediate cause(a) Severe heart disease  
DUE TO(b) Alimentary HCV disease  
DUE TO

(c)

## 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes  No 21. ACCIDENT  
SUICIDE  
HOMICIDE

(Specify)

PLACE (Home, farm, factory, street,  
OF office bldg., etc.)  
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)  
OF INJURY

INJURY

While at  
m.Not While  
Work   
At Work 

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb. 16, 1955, to Feb. 17, 1955, that I last saw the deceased alive on Feb. 16, 1955, and that death occurred at 5 pm, from the causes and on the date stated above.

SIGNATURE  
J. A. K. Brown, M.D.ADDRESS  
Chestnut and PrattDATE SIGNED  
Feb. 17, 195523. BURIAL, CREMATION,  
REMOVAL  
(Specify)

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORIUM

## LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL  
REGISTRAR

## REGISTRAR'S SIGNATURE

John B. Loughran

Cedar

Huff

FUNERAL DIRECTOR

John M. Taylor & Sons

Annapolis, Md.

ADDRESS

Feb. 19, 1955Feb. 24, 1955

REGISTRAR'S SIGNATURE

P. B. E. L.

FUNERAL DIRECTOR

John M. Taylor & Sons

Annapolis

MD

BUREAU V. S

MAR 2 1965

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01670

1688

## CERTIFICATE OF DEATH

Reg. Dist. No. 194

1. PLACE OF DEATH: COUNTY <u>Howard</u> MARYLAND CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>near Fulton</u> LENGTH OF STAY (in this place) 3 months				2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Md</u> COUNTY <u>Prince George</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>College Park</u> 14 STREET ADDRESS <u>7504 Princeton Avenue</u>			
3. NAME OF DECEASED: (First) <u>Ella</u> (Middle) <u>J.</u> (Last) <u>Kruehm</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>February 27 1955</u>			
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>w</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>married</u>	8. DATE OF BIRTH: <u>March 27 1872</u>	9. AGE last birthday <u>82 yrs.</u>	IF UNDER 1 YEAR <u>Months</u>	IF UNDER 24 HRS. <u>Days</u>	IF UNDER 24 HRS. <u>Hours</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>housewife</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>own home</u>			
11. BIRTHPLACE (State or foreign country): <u>Howard Co Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME: <u>Philip J. Beall</u>				14. MOTHER'S MAIDEN NAME: <u>Ann Amelia Penry</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. _____			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>420.0</u>							
IMMEDIATE CAUSE (A) DUE TO <u>Chronic myocardial failure</u>							
ANTECEDENT CAUSE (S) (B) DUE TO <u>arterosclerotic heart disease</u>							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec 28 1954</u> to <u>Feb 27 1955</u> , that I last saw the deceased alive on <u>Feb. 27 1955</u> , and that death occurred at <u>1115A</u> M, from the causes and on the date stated above. SIGNATOR: <u>Charles S. Whitaker</u> ADDRESS <u>Clarksville, Md.</u> DATE SIGNED <u>2/28/55</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>March 1, 1955</u>		NAME OF CEMETERY OR CREMATORIAL <u>St Paul's Cemetery</u>		LOCATION (City, town, or county) (State) <u>Fulton, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>3-1-55</u>		REGISTRAR'S SIGNATURE <u>Marie A. Whitaker</u>		24. FUNERAL DIRECTOR <u>DeWitt Donaldson, Laurel, Md.</u>		ADDRESS	

BUREAU V. S.

MAR 2 1955

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02746

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

No. 192

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

## I. PLACE OF DEATH:

COUNTY Howard

MARYLAND

CITY (If outside corporate limits, write RURAL  
OR and give nearest town)  
TOWN FlorenceLENGTH OF STAY  
(in this place)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Baltimore

CITY (If outside corporate limits write RURAL and give nearest town)  
OR  
TOWN Daniels

03X-2

HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESSSTREET  
ADDRESS  
(If rural, give location)  
6908 Dogwood Road3. NAME OF  
DECEASED:  
(Type or Print)(First) JOSEPH LEE LE RENDU  
(Middle)

(Last)

4. DATE  
OF  
DEATH  
2-4-55  
(Month) (Day) (Year)5. SEX:  
Male6. COLOR OR  
RACE:  
White7. SINGLE, MARRIED,  
WIDOWED, DIVORCED,  
(Specify) Single8. DATE OF BIRTH:  
11-20-549. AGE last birthday:  
IF UNDER 1 YEAR  
yrs. 2 Months 15 Days Hours Min.10a. USUAL OCCUPATION (Give kind of  
work done during most of work life,  
even if retired) None10b. KIND OF BUSINESS OR  
INDUSTRY:11. BIRTHPLACE (State or foreign country):  
Maryland12. CITIZEN OF WHAT  
COUNTRY?

## 13. FATHER'S NAME:

Leslie R. Le Rendu

## 14. MOTHER'S MAIDEN NAME:

Katie Compton

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unk.) (If Yes, give war or dates of  
service)

No

16. SOCIAL SECURITY NO.: None

## 17. INFORMANT &amp; ADDRESS:

Leslie Le Rendu, Daniels, Md

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

391.2  
Immediate cause

(a) DUE TO

Purulent Otitis Media  
With SepticemiaINTERVAL BETWEEN  
ONSET AND DEATH

Antecedent cause(s)

Diseases or conditions, if any, (b)...  
giving rise to the above cause DUE TO  
stating underlying cause last (c)II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH.

## 19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

## 20. AUTOPSY?

Yes  No 21a. EXTERNAL CAUSE WAS  
PRIMARY  or CONTRIBUTING   
CAUSE OF DEATH.21d. TIME (Month) (Day) (Year) (Hour)  
OF  
INJURY21b. PLACE (Home, farm, factory,  
OF street, office bldg., etc.,  
INJURY)

21c. (City or town) (County)

(State)

While at work Not while at work 

## 21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and find that death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined cause .  
SIGNATURE George E. RutherfordCHIEF MEDICAL EXAMINER  
DEPUTY MEDICAL EXAMINER  
ASSISTANT MEDICAL EXAM.DATE SIGNED  
2-4-5523. BURIAL, CREMATION,  
REMOVAL (Specify): Burial

DATE THEREOF NAME OF CEMETERY OR CREMATORIAL

LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL  
REG. 2-7-55

REGISTRAR'S SIGNATURE John C. Langford

24. FUNERAL DIRECTOR

ADDRESS

Per B. E. &amp; Pearl Mercury

RECEIVED  
FEBRUARY 28 1968

MAR 28 1968

FEDERAL BUREAU OF INVESTIGATION

## MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

01671

1690  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 195  
Reg. Dist.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <b>Howard</b>	MARYLAND	STATE <b>Maryland</b>	COUNTY <b>Howard</b>
CITY (If outside corporate limits, write RURAL OR and give nearest town)		CITY (If outside corporate limits write RURAL and give nearest town)	
TOWN <b>Jessups</b>	LENGTH OF STAY (in this place)	TOWN <b>Jessups</b>	STREET ADDRESS <b>rural</b>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>One Spot</b>		(If rural, give location) <b>One Spot</b>	
3. NAME OF DECEASED: (First) <b>CHARLES</b>	(Middle) <b>MC KINLEY</b>	(Last) <b>NELSON</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>2-25-55</b>
5. SEX: <b>Male</b>	6. COLOR OR RACE: <b>Colored</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Single</b>	8. DATE OF BIRTH: <b>10-18-1954</b>
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY: <b>None</b>	11. BIRTHPLACE (State or foreign country): <b>Howard County, Md</b>
13. FATHER'S NAME: <b>Russell Purnell Nelson</b>		14. MOTHER'S MAIDEN NAME: <b>Shirley Mitchell</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <b>No</b>		16. SOCIAL SECURITY NO.: <b>None</b>	
(If Yes, give war or dates of service)		17. INFORMANT & ADDRESS: <b>Shirley Mitchell Nelson, Jessups, Md</b>	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:  916.0 Immediate cause (a) <b>Second and Third Degree Burns of</b> DUE TO <b>upper 1/2 of body</b> <span style="float: right;">INTERVAL BETWEEN ONSET AND DEATH <b>instant</b></span>			
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c) <b>-</b>			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <b>none</b>			
19a. DATE OF OPERATION: <b>none</b>	19b. MAJOR FINDING OF OPERATION: <b>none</b>	20. AUTOPSY? <b>Yes</b> <input type="checkbox"/> <b>No</b> <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <b>Home</b> )	21c. (City or town) <b>Jessups</b>	(County) <b>Howard</b> (State) <b>Md.</b>
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <b>2 25 1955 10 A.M.</b>	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>House caught fire with children in it.</b>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . SIGNATURE <b>Eugene E. Bunting</b>			
23. BURIAL, CREMATION, REMOVAL (Specify): <b>Burial</b>	DATE THEREOF <b>2-28-55</b>	NAME OF CEMETERY OR CREMATORIAL <b>One Spot</b>	LOCATION (City, town, or county) (State) <b>Jessups Md.</b>
DATE REC'D BY LOCAL REG. <b>Feb. 28, 1955</b>	REG. <b>Frank Shirley</b>	REG. <b>Frank Shirley</b>	REG. <b>Frank Shirley</b>
REG. <b>Frank Shirley</b>		24. FUNERAL DIRECTOR <b>F.C. Higinbotham, Ellicott City, Md</b>	ADDRESS

1004182405

BUREAU V. S

MAR 3 1966

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

1691

2411 N. Charles Street, Baltimore

01672

CERTIFICATE OF DEATH

Reg. Dist. No. 191

1. PLACE OF DEATH: COUNTY Howard		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN Ellicott City		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Ellicott City	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Columbia Road		STREET ADDRESS Columbia Road (If rural, give location)	

3. NAME OF DECEASED (Type or Print)	(First) TALTON	(Middle) JOHN	(Last) PURKEY	4. DATE OF DEATH 2-14-55	(Month) 19
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 5-13-1913	9. AGE last birthday 41	10. under 1 year Months Days Hours yrs.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver	10b. KIND OF BUSINESS OR INDUSTRY Feed Mill	11. BIRTHPLACE (State or foreign country) Tenn	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Flaner Purkey	14. MOTHER'S MAIDEN NAME Ellen Purkey		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. 217-18-1738	17. INFORMANT AND ADDRESS Lilly Purkey, Ellicott City, Md	

18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
420.1 Immediate cause (a) Acute cardiac failure			
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Coronary artery occlusion			
(c)			

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
---	--	--	--

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) OF INJURY	(Hour) m. INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?  

22. I hereby certify that I attended the deceased from Jan 14, 1955, to Feb 14, 1955, that I last saw the deceased alive on Feb 14, 1955, and that death occurred at 4:30 A.m., from the causes and on the date stated above.			
SIGNATURE Charles S. Whitaker, M.D.	(Degree or title) ADDRESS Clarksville, Md.	DATE SIGNED 2/14/55	

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF 2/16/1955	NAME OF CEMETERY OR CREMATORIAL Lisbon Good Shepherd Cemetery	LOCATION (City, town, or county) Ellicott City (State)
DATE REC'D BY LOCAL REG. Feb 14, 1955	REGISTRAR'S SIGNATURE John B. Loughran	24. FUNERAL DIRECTOR F.C. Higginbotham, Ellicott City	ADDRESS Md.
Per B.E.L.			

RECEIVED  
BUREAU V. S.

REC 18 1955

1692

## CERTIFICATE OF DEATH

Reg. Dist. No. 191

## 1. PLACE OF DEATH:

COUNTY Howard MARYLAND  
 CITY (If outside corporate limits, write RURAL  
 OR  
 and give nearest town)  
 TOWN Ellicott City LENGTH OF STAY  
 (in this place)

HOSPITAL OR  
 INSTITUTION OR  
 STREET ADDRESS Highland Manor Nursing Home

3. NAME OF  
 DECEASED:  
 (First) (Middle) (Last)

JOSEPH W. RENEHAN

5. SEX: 6. COLOR OR 7. SINGLE, MARRIED,  
 RACE: WIDOWED, DIVORCED.  
 male white (Specify): Divorced

8. DATE OF BIRTH:  
 July 28, 1896

9. AGE last birthday  
 58 IF UNDER 1 YEAR  
 yrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of  
 work done during most of working life,  
 even if retired): Salesman

10B. KIND OF BUSINESS  
 OR INDUSTRY:  
 Insurance

11. BIRTHPLACE (State or foreign country):  
 Baltimore, Maryland 12. CITIZEN OF WHAT  
 COUNTRY?  
 U. S. A.

13. FATHER'S NAME:  
 ---

14. MOTHER'S MAIDEN NAME:  
 ---

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
 (Yes, no, or unk.) (If Yes, give war or dates  
 of service) no

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS:

Joan Renehan, 2725 St. Paul Street

18. MEDICAL CERTIFICATION  
 I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

592X  
 IMMEDIATE CAUSE

(A)  
 DUE TO

*Chronic Nephritis with*

INTERVAL BETWEEN  
 ONSET AND DEATH

ANTECEDENT CAUSE (S):

*Edema*

2-3 yrs

DISEASES OR CONDITIONS, IF ANY,  
 GIVING RISE TO THE ABOVE CAUSE  
 STATING UNDERLYING CAUSE LAST.

(B)  
 DUE TO  
 (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
 TO THE DEATH BUT NOT RELATED TO THE  
 DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?  
 YES  NO

21A. ACCIDENT WAS UNDERLYING   
 OR CONTRIBUTING  CAUSE OF DEATH  
 (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory,  
 OF INJURY street, office bldg., etc.)

21C. WHERE DID (City or town)  
 INJURY OCCUR?

(County) (State)

21D. TIME (Month) (Day) (Year) (Hour)  
 OF INJURY

21E. INJURY OCCURRED  
 While  Not while   
 at work  at work

21F. HOW DID INJURY OCCUR?

M.   
 22. I hereby certify that I attended the deceased from *Nov*, 1954 to *Feb 3*, 1955 that I last saw the deceased  
 alive on *Feb 1*, 1955, and that death occurred at *6:54 AM*, from the causes and on the date stated above.  
 SIGNATURE *Robert B. Taylor* ADDRESS *Ellicott City Md* DATE SIGNED

23. BURIAL, CREMATION,  
 REMOVAL (SPECIFY)  
*Burial*

DATE THEREOF  
*2/5/55*

NAME OF CEMETERY OR CREMATORIAL  
*New Cathedral*

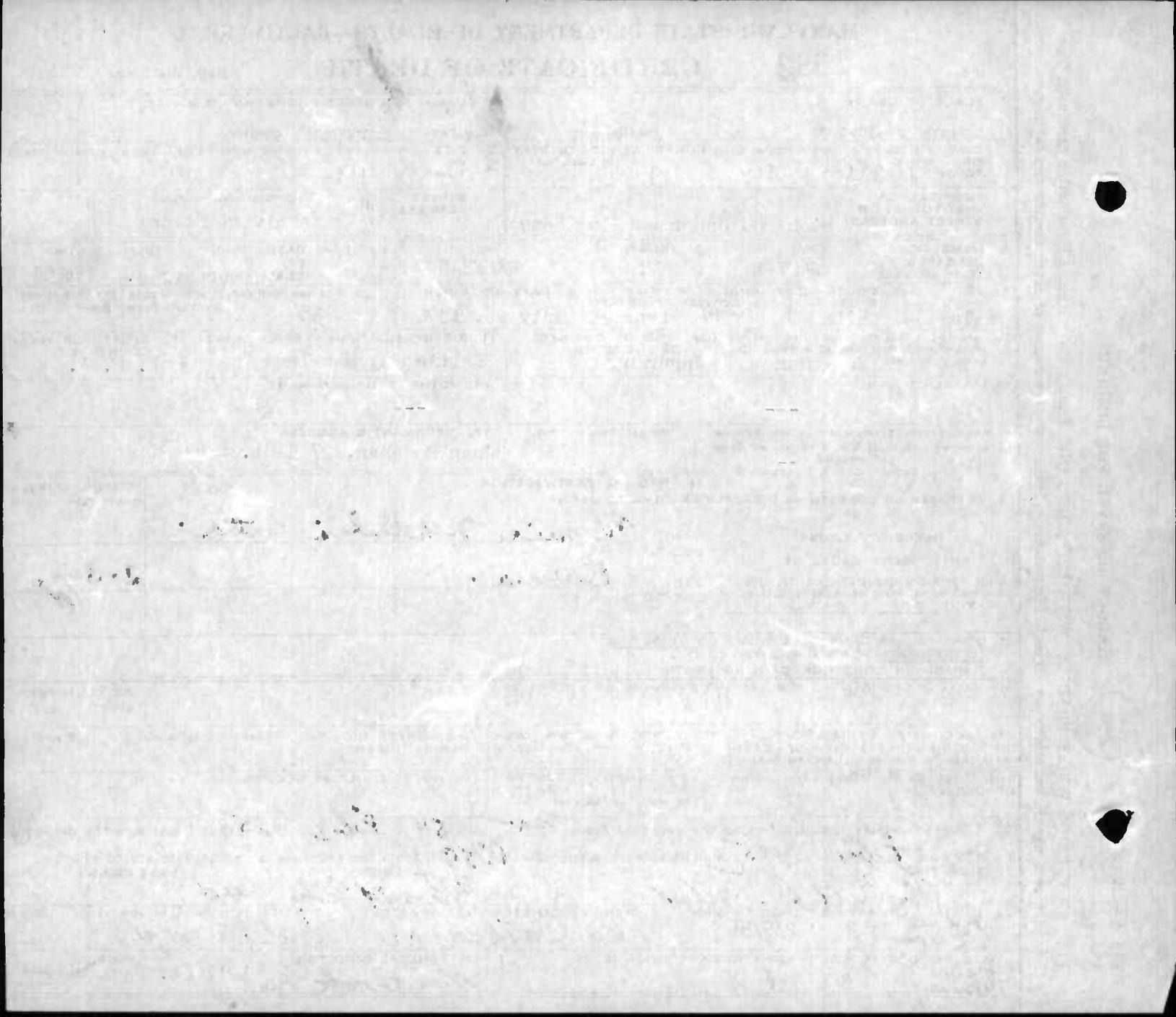
LOCATION (City, town, or county) (State)  
*Baltimore Md*

DATE REC'D BY LOCAL  
 REGISTRAR  
*February 5, 1955*

REGISTRAR'S SIGNATURE  
*RW*

24. FUNERAL DIRECTOR

ADDRESS  
*1217 St. Paul Street*



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01674

1693

## CERTIFICATE OF DEATH

Reg. Dist. No. 190

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	MARYLAND LENGTH OF STAY (in this place)	STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	COUNTY STREET ADDRESS (If rural give location)
Hanover Jesup 00	25 yrs.	Maryland Jesup	X
3. NAME OF DECEASED: (First) (Middle) (Type or Print)	(Last)	4. DATE OF DEATH: FEB. 7 1955	
Henry	Sanders		
5. SEX: M W	6. COLOR OR RACE: SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Indured Sept 19, 1878	8. DATE OF BIRTH: 10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): restaurant owner	9. AGE last birthday: IF UNDER 1 YEAR 76 yrs. Months Days Hours Min. 12. CITIZEN OF WHAT COUNTRY? USA
		10b. KIND OF BUSINESS OR INDUSTRY: restaurant	
13. FATHER'S NAME: unknown	14. MOTHER'S MAIDEN NAME: unknown		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) no	16. SOCIAL SECURITY NO.: _____	17. INFORMANT & ADDRESS: C. W. Jess, Mission Rd, Jesup, Md	Interval Between Onset And Death 2 WKS
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 420.1 Immediate cause (a) DUE TO MYOCARDIAL INFARCTION Antecedent causes (s) (b) DUE TO ARTERIO SCLEROSIS Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION		
20. AUTOPSY ? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) OF INJURY	(Day) (Year) m.	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR ?
22. I hereby certify that I attended the deceased from 6 FEB. 1955, to 7 Feb. 1955, that I last saw the deceased alive on 6 Feb. 1955, and that death occurred at 1:25 AM, from the causes and on the date stated above. SIGNATURE (Degree or title) ADDRESS DATE SIGNED			
George E. Gulean MD		Chesapeake, Md	7 Feb. 55
23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORIUM	LOCATION (City, town, or county) (State)
Burial	Feb. 19, 1955	Parkwood Cemetery	Baltimore, Maryland
DATE REGD BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb. 6-55	E. Bird Williams	DeWitt Donaldson, Laurel, Md	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU Y.

FEB 11 1955

RECEIVED

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

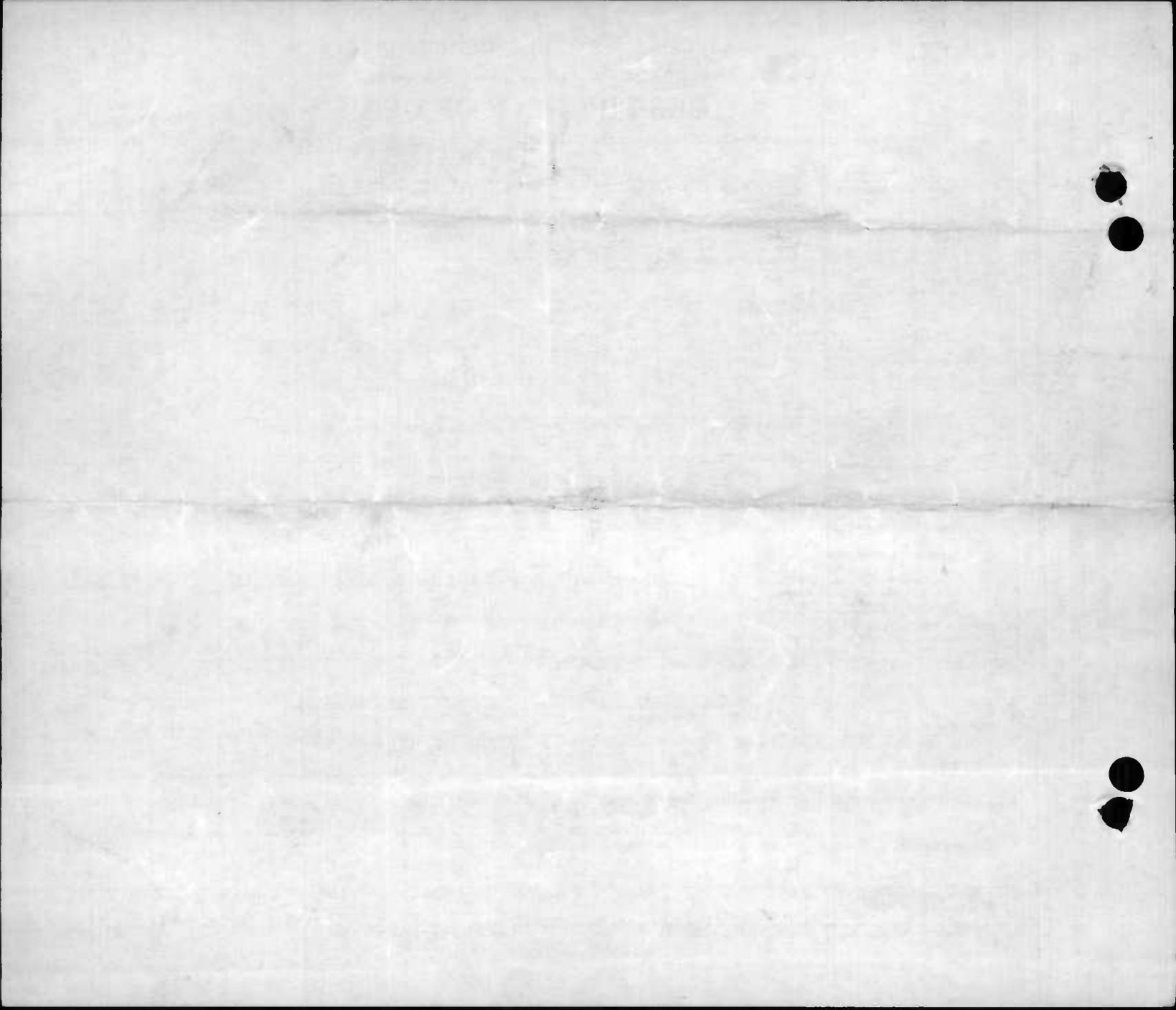
MARYLAND STATE DEPARTMENT OF HEALTH  
1694 2411 N. Charles Street, Baltimore

01675

Reg. Dist. No. 191

## CERTIFICATE OF DEATH

1. PLACE OF DEATH COUNTY <u>Howard</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <u>ELLIOTT CITY</u>		LENGTH OF STAY (in this place) <u>1 year</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Shaffer's Nursing Home</u>		STREET ADDRESS <u>1236. Ostend St.</u>	
3. NAME OF DECEASED (Type or Print) <u>Louis</u>		4. DATE OF DEATH <u>Feb. 16,</u> <u>1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>11-22-75</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BAKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>	9. AGE last birthday <u>79</u> yrn. If under 1 year Months Days Hours Min.
13. FATHER'S NAME <u>Unknown</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Louis Schoene, Sr. ELLICOTT CITY, Md.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>443 X</u> Immediate cause (a) <u>Cerebral embolism</u>			
Antecedent cause(s) (b) <u>Arterosclerotic CV disease with hypertension</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
5 yrs -			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) OF INJURY	(Day) m.	INJURY OCCURRED While at Work <input type="checkbox"/> At work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <u>Jan 1, 1955</u> , to <u>Feb 16, 1955</u> , that I last saw the deceased alive on <u>Feb 15, 1955</u> , and that death occurred at <u>301 1037 Collett St.</u> m., from the causes and on the date stated above.			
SIGNATURE <u>John A. Kornman, M.D.</u>		ADDRESS <u>Baltimore</u>	DATE SIGNED <u>2/17/55</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>	DATE <u>2-19-55</u>	NAME OF CEMETERY OR CREMATORIAL <u>CEDAR HILL</u>	LOCATION (City, town, or county) (State) <u>Anne Arundel County, Md.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS <u>George L. Schubert 2101 Frederick Ave.</u>	



## MARYLAND STATE DEPARTMENT OF HEALTH

1695

2411 N. Charles Street, Baltimore

01676

## CERTIFICATE OF DEATH

Reg. Dist. No. 19.

1. PLACE OF DEATH COUNTY Howard MARYLAND			2. USUAL RESIDENCE (HOME) OF DECEASED. STATE Maryland COUNTY Howard		
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Ellicott City			CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Ellicott City		
HOSPITAL OR INSTITUTION OR STREET ADDRESS			STREET ADDRESS (If rural, give location)		
3. NAME OF DECEASED (Type or Print) Edward			4. DATE OF DEATH 2 22 19 55 Shipley		
5. SEX M	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH 7/24/1865	9. AGE last birthday 89 yrs.	10. KIND OF BUSINESS OR INDUSTRY building
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) carpenter			11. BIRTHPLACE (State or foreign country) Carroll County		
13. FATHER'S NAME John Wesley Shipley			12. CITIZEN OF WHAT COUNTRY?		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. none		
17. INFORMANT AND ADDRESS Hilda Shipley, Ellicott City, Md.			18. MEDICAL CERTIFICATION 450.1 Immediate cause (a) GANGRENE, LEFT LEG Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) ARTERIO SCLEROSIS (c) CONGESTIVE HEART FAILURE		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			INTERVAL BETWEEN ONSET AND DEATH 2 months years		
19a. DATE OF OPERATION None			19b. MAJOR FINDINGS OF OPERATION		
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>					
21. ACCIDENT SUICIDE HOMICIDE	(Specify) None	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)		(COUNTY) (STATE)
TIME (Month) OF INJURY	(Day) —	(Year) —	(Hour) m.	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from Nov. 1954, to Feb. 1955, that I last saw the deceased alive on FEB. 22, 1954, and that death occurred at 12 15 p.m., from the causes and on the date stated above. SIGNATURE (Degree or title) ADDRESS DATE SIGNED Donald E. Fisher M.D. Ellicott City, Md. Feb. 23, 1955					
23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF 2/25/55	NAME OF CEMETERY OR CREMATORIUM St. Johns	LOCATION (City, town, or county) (State) Ellicott City, Md.		
DATE REC'D BY LOCAL REG. Feb. 23, 1955	REGISTRAR'S SIGNATURE John B. Loughran Jr.	24. FUNERAL DIRECTOR F.C. Higinbotham	ADDRESS Ellicott City, Md.		

BUREAU V. S.

FEB 28 1955

RECEIVED

01677

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct  
age is especially important. Physicians: please write the causes of death clearly and legibly.

## 1. PLACE OF DEATH:

COUNTY Howard

MARYLAND

CITY (If outside corporate limits, write RURAL  
OR and give nearest town)  
TOWN N. LaurelLENGTH OF STAY  
(in this place)HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS  
000 Rt. 1; 20 feet north of  
Whiskey Bottom Road3. NAME OF  
DECEASED:  
(First) ROSALIE (Middle) SILVERMAN (Last)4. SEX: Female RACE: White 6. COLOR OR  
7. SINGLE, MARRIED,  
WIDOWED, DIVORCED.  
(Specify Single)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md

COUNTY

CITY (If outside corporate limits write RURAL and give nearest town)  
OR  
TOWN Baltimore10a. USUAL OCCUPATION (Give kind of  
work done during most of work life,  
if applicable): College Student10b. KIND OF BUSINESS OR  
INDUSTRY:STREET  
ADDRESS

(If rural, give location)

3733 Clarendon Road ✓

4. DATE  
OF  
DEATH 2-28-1955 199. AGE last birthday: IF UNDER 1 YEAR  
2 4 yrs. Months Days Hours Min.

## 13. FATHER'S NAME:

Abe Silverman

## 14. MOTHER'S MAIDEN NAME:

Lillian Fettleman

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unk.) (If Yes, give war or dates of  
service)

16. SOCIAL SECURITY NO.: 218-26-1983

17. INFORMANT &amp; ADDRESS:

Lillian Silverman - Dancer

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

816 X

Immediate cause

(a) Compound, Comminuted Fracture of Skull

DUE TO

INTERVAL BETWEEN  
ONSET AND DEATH

Instant

## Antecedent cause(s)

Diseases or conditions, if any, (b)...  
giving rise to the above cause DUE TO  
stating underlying cause last (c)II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH.

## 19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

## 20. AUTOPSY?

Yes  No 21a. EXTERNAL CAUSE WAS  
PRIMARY  or CONTRIBUTING   
CAUSE OF DEATH21b. PLACE (Home, farm, factory,  
of street, office bldg., etc.,  
INJURY RT. 1 U.S. N. Laurel Howard

(County)

(State)

Md

21d. TIME (Month) (Day) (Year) (Hour) 21e. INJURY OCCURRED  
OF INJUR 2-28-55 9AM While at Not while  
M. work  at work 

21f. HOW DID INJURY OCCUR?

Head on collision  
with tractor trailer.22. I hereby certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and  
find that death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined cause   
SIGNATURE George E. PenningtonCHIEF MEDICAL EXAMINER  
DEPUTY MEDICAL EXAMINER  
ASSISTANT MEDICAL EXAM.DATE SIGNED  
2-28-195523. BURIAL, CREMATION,  
REMOVAL (Specify): DATE THEREOF NAME OF CEMETERY OR CREMATORIAL LOCATION (City, town, or county) (State)  
Burial 3-1-55 Rosedale Baltimore MdDATE REC'D BY LOCAL REG. REGISTRAR'S SIGNATURE FUNERAL DIRECTOR ADDRESS  
March 1, 1955 J.W. Hedrich Jack Lewis Inc 2100 Eutaw Pl



## 1697 CERTIFICATE OF DEATH

Reg. Dist. No. 191

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Howard</u> CITY (if outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Ellicott City</u>		MARYLAND LENGTH OF STAY (in this place) <u>2 days</u> STATE <u>Md.</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Oella</u> STREET ADDRESS <u>Pleasant Hill</u>	
3. NAME OF DECEASED: (First) <u>ADA</u> (Middle) <u>GERTRUDE</u> (Last) <u>SIMS</u> (Type or Print)		4. DATE (Month) <u>Feb.</u> (Day) <u>22</u> (Year) <u>1955</u> OF DEATH:	
5. SEX: <u>F.</u> 6. COLOR OR RACE: <u>W.</u> 7. SINGLE, MARRIED, WIDOWED, DIVORCED. Specify: <u>Married</u>		8. DATE OF BIRTH: <u>May 5, 1877</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life. Specify if retired: <u>Weaver (Retired)</u> )		10B. KIND OF BUSINESS OR INDUSTRY: <u>Woolen Mill</u>	
13. FATHER'S NAME: <u>George W. Jones</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
16. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>422.1</u> IMMEDIATE CAUSE <u>Arturoesclerotic Vascular Disease</u> ANTECEDENT CAUSE (S) <u>Diabetes Mellitus</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>260X</u> (A) DUE TO <u>None</u> (B) DUE TO <u>None</u> (C)		17. INFORMANT & ADDRESS: <u>Oella, Md.</u> <u>Arthur Sims - Pleasant Hill</u>	
		INTERVAL BETWEEN ONSET AND DEATH <u>4 years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Diabetes Mellitus</u>		<u>3 years.</u>	
19A. DATE OF OPERATION: <u>None</u>		19B. MAJOR FINDINGS OF OPERATION <u>None</u>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>Elliot City, Md.</u>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>M.</u>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11/29, 1952</u> , to <u>2/22, 1955</u> that I last saw the deceased alive on <u>2/21, 1955</u> , and that death occurred at <u>5:30 AM</u> , from the causes and on the date stated above. SIGNATURE <u>George S. Burdorf M.D.</u> ADDRESS <u>Elliot City, Md.</u> DATE SIGNED <u>2/23/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2-25-55</u> NAME OF CEMETERY OR CREMATORIAL <u>Good Shepherd</u> LOCATION (City, town, or county) <u>Ellicott City, Md.</u> (State)	
DATE REC'D BY LOCAL REGISTRAR <u>Feb 23, 1955</u>		REGISTRAR'S SIGNATURE <u>John B. Longman, Esq.</u> FUNERAL DIRECTOR ADDRESS <u>Taylor Sons Catonsville Md.</u>	

RECEIVED  
BUREAU V. S.

FEB 28 1955

MARYLAND

1698

STATE DEPARTMENT OF HEALTH  
01679

## CERTIFICATE OF DEATH

Reg. Dist. No. 195

1. PLACE OF DEATH. COUNTY <i>Howard</i>		2. USUAL RESIDENCE (HOME) OF DECEASED. STATE <i>MARYLAND</i> COUNTY <i>Maryland</i>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <i>TOWN Highridge, Laurel</i>		LENGTH OF STAY (in this place) <i>20 yrs</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>00</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN STREET ADDRESS <i>Highridge, Laurel</i>	
3. NAME OF DECEASED (Type or Print) <i>Edward</i>		4. DATE OF DEATH <i>February 8 1955</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH <i>Sept 21 1871</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Cabover</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>State road commission</i>	9. AGE last birthday <i>83 yrs</i>
13. FATHER'S NAME <i>Isaac Sullivan</i>		11. BIRTHPLACE (State or foreign country) <i>Clearmont Valley, Md</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
16. SOCIAL SECURITY NO. (If year, give war or dates of service)		14. MOTHER'S MAIDEN NAME <i>Mary Jane Townsend</i>	
18. MEDICAL CERTIFICATION I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <i>141X</i> Immediate cause <i>(a)....</i> Antecedent cause(s) <i>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b).... (c)....</i>		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <i>Malnutrition Gastric Ulcer Metastasis to Cervical Nodes Hypertension, Arteriosclerosis 10 yrs</i>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <i>Malnutrition Gastric Ulcer Metastasis to Cervical Nodes Hypertension, Arteriosclerosis 10 yrs</i>	
20. AUTOPSY? <input type="checkbox"/> Yes <input type="checkbox"/> No		INTERVAL BETWEEN ONSET AND DEATH <i>10 wks</i>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at m. Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR? <i>600 A.m.</i>
22. I hereby certify that I attended the deceased from <i>12/27, 1946</i> to <i>2/8</i> , 1955, that I last saw the deceased alive on <i>2/5/55</i> , 1955, and that death occurred at <i>600 A.m.</i> from the causes and on the date stated above. SIGNATURE <i>M. Warren and Laurel</i> DATE SIGNED <i>2/8/55</i> (Degree or title) ADDRESS			
23. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>		DATE <i>2/1/55</i>	NAME OF CEMETERY OR CREMATORIUM <i>Emmanuel Cemetery</i>
DATE REC'D BY LOCAL REC. <i>Feb 10 - 55</i>		REGISTRAR'S SIGNATURE <i>Frank Shipton</i>	LOCATION (City, town, or county) (State) <i>Scaggsville, Md</i>
24. FUNERAL DIRECTOR <i>Dr. W.H. Danaldson, Laurel Md</i>		ADDRESS	
+ m.s.			

BUREAU Y. S.

MAR 1 1955

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH

02754

1699

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH: COUNTY <b>Howard</b>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <b>Maryland</b>		COUNTRY <b>Howard</b>				
CITY (If outside corporate limits, write RURAL and OR give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR				
TOWN <b>Rural - Woodbine</b>		34 years		TOWN <b>Rural - Woodbine</b>		STREET (If rural, give location)				
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Rt. 1 - Old Frederick Road</b>				ADDRESS <b>Rt 1. Old Frederick Road'</b>						
3. NAME OF DECEASED (Type or Print) <b>Rudolph</b>		(First) <b>Rudolph</b>	(Middle)	(Last) <b>Tragard</b>		4. DATE OF DEATH <b>Feb.</b>	(Month) <b>5</b>	(Day) <b>1955</b>		
5. SEX <b>Male</b>		6. COLOR OR RACE <b>white</b>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Widowed</b>		8. DATE OF BIRTH <b>June 17, 1865</b>	9. AGE last birthday Months. <b>89</b>	If under 1 year Days <b>11</b>	If under 24 hrs. Hours <b>5</b>	Min. <b>15</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Commercial Artist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Commercial Art</b>		11. BIRTHPLACE (State or foreign country) <b>Illinois</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>				
13. FATHER'S NAME <b>Rudolph Tragard</b>				14. MOTHER'S MAIDEN NAME <b>Emma Brandt</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>		16. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT AND ADDRESS <b>Mrs. Ridgely Rue, Woodbine, Md.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 Day</b>				
18. MEDICAL CERTIFICATION										
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH										
<b>331X</b> Immediate cause		(a) <b>Cerebral Hemorrhage</b>								
Antecedent cause(s)		(b) <b>Arteriosclerosis, Generalized</b>								
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		(c) <b>10 years</b>								
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.										
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION								
20. AUTOPSY?										
Yes <input type="checkbox"/> No <input type="checkbox"/>										
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN)		(COUNTY)		(STATE)		
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>		HOW DID INJURY OCCUR?						
22. I hereby certify that I attended the deceased from <b>Feb 4</b> , 1955, to <b>Feb 5</b> , 1955, that I last saw the deceased alive on <b>Feb 4</b> , 1955, and that death occurred at <b>7 P.m.</b> , from the causes and on the date stated above.										
SIGNATURE <b>W.B. Culwell, M.D.</b>		(Degree or title) <b>mt. airy</b>		ADDRESS		DATE SIGNED <b>Feb 5, 1955</b>				
23. BURIAL, CREMATION REMOVAL (Specify) <b>CREMATION</b>		DATE <b>2-8-1955</b>		NAME OF CEMETERY OR CREMATORIUM <b>Loudon Park</b>		LOCATION (City, town, or county) <b>Baltimore, Maryland</b>				
DATE REC'D BY LOCAL REG. <b>3/21/55</b>		REGISTRAR'S SIGNATURE <b>E. Pearl Merriweather</b>		24. FUNERAL DIRECTOR ADDRESS <b>C. M. Waltz, Winfield, Maryland</b>						

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED

MAR 22 1955

BUREAU V. S.

1700

Item 12, Film G177 2-15-55 et

01680

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No.

## I. PLACE OF DEATH:

COUNTY Howard

MARYLAND

CITY (If outside corporate limits, write RURAL  
OR and give nearest town)  
TOWN Ellicott CityLENGTH OF STAY  
(In this place)  
2 daysHOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS 90  
Highland Manor, Church  
St., Ellicott City, Md.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md.

COUNTY Baltimore City

CITY (If outside corporate limits write RURAL and give nearest town)  
OR  
TOWN Baltimore, Md.

3101-4

STREET ADDRESS  
(If rural, give location)  
2316 Ocala Avenue3. NAME OF  
DECEASED:  
(Type or Print)

Samuel

(Middle)

(Last)

4. DATE  
OF  
DEATH(Month) (Day) (Year)  
2 9 1955

## 5. SEX:

Male

6. COLOR OR  
RACE:

White

7. SING. E. MARRIED,  
WIDOWED, DIVORCED.  
(Specify):

Married

## 8. DATE OF BIRTH:

48

yrs.

9. AGE last birthday:  
IF UNDER 1 YEAR  
Months Days Hours Min.10a. USUAL OCCUPATION (Give kind of  
work done during most of work life,  
even if retired)

manager

10b. KIND OF BUSINESS OR  
INDUSTRY:

Cleaning

## 11. BIRTHPLACE (State or foreign country):

Australia

12. CITIZEN OF WHAT  
COUNTRY?

USA

## 13. FATHER'S NAME:

David

## 14. MOTHER'S MAIDEN NAME:

Jessie Mintzer

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unk.)(If Yes, give war or dates of  
service)

## 16. SOCIAL SECURITY NO.:

17. INFORMANT &amp; ADDRESS:

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

420.1  
Immediate cause

(a).....

Coronary Thrombosis

INTERVAL BETWEEN  
ONSET AND DEATH  
5 min.

## Antecedent cause(s)

Diseases or conditions, if any, (b).  
giving rise to the above cause DUE TO  
stating underlying cause last (c)II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH.

## 19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

## 20. AUTOPSY?

Yes  No 21a. EXTERNAL CAUSE WAS  
PRIMARY  or CONTRIBUTING  CAUSE OF DEATH.21b. PLACE (Home, farm, factory,  
of street, office bldg., etc.,  
INJURY)

## 21c. (City or town) (County) (State)

21d. TIME (Month) (Day) (Year) (Hour)  
OF INJURY M.21e. INJURY OCCURRED  
While at Not while  
work  at work 

## 21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and  
find that death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined cause .

## SIGNATURE

George S. Burttorff

CHIEF MEDICAL EXAMINER  
DEPUTY MEDICAL EXAMINER  
M. D. ASSISTANT MEDICAL EXAM.DATE SIGNED  
2/9/5523. BURIAL, CREMATION,  
REMOVAL (Specify): DATE THEREOF NAME OF CEMETERY OR CREMATORIAL LOCATION (City, town, or county) (State)  
removal 2-10-55 New York N.Y.

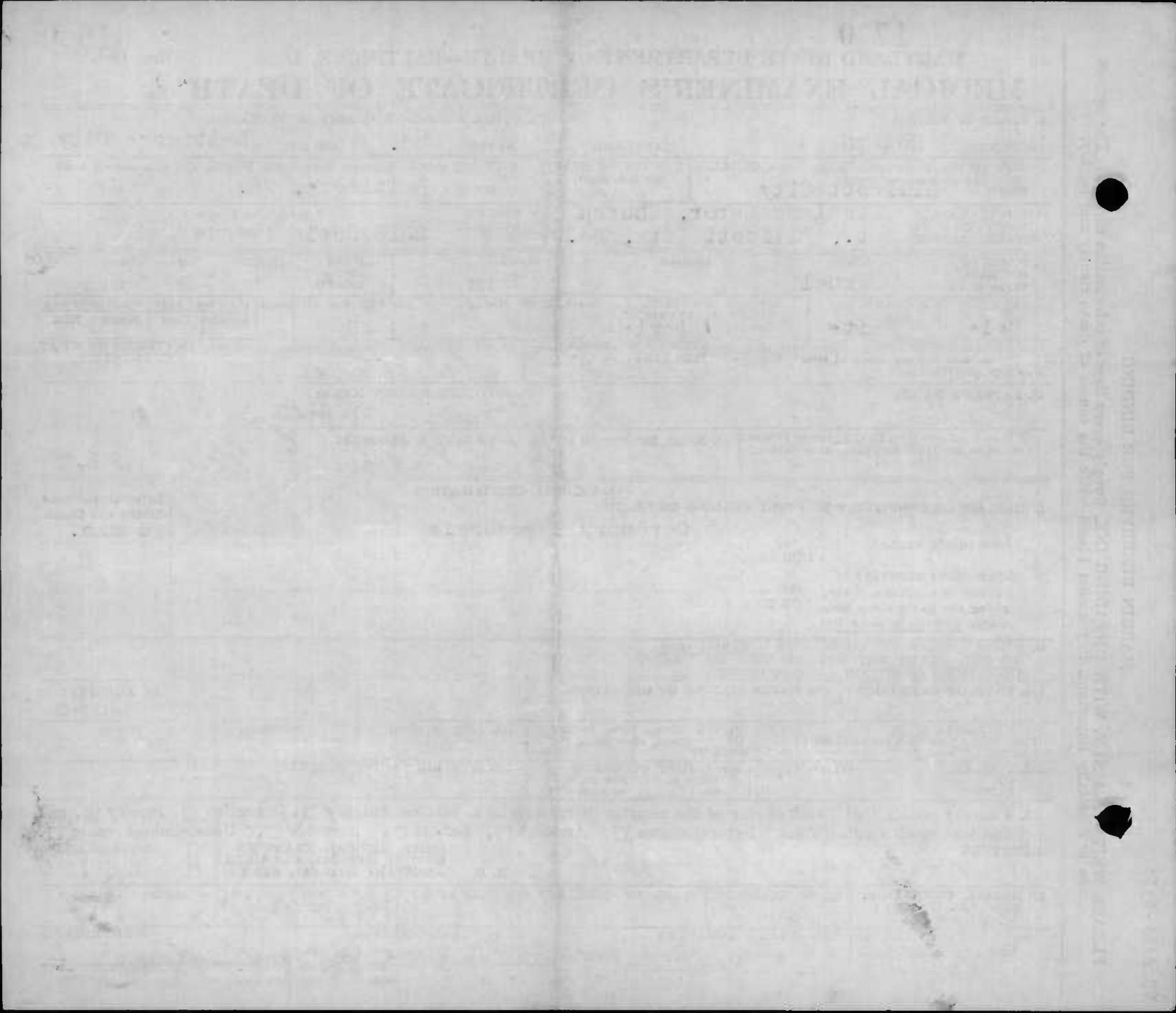
DATE REC'D BY LOCAL REG. REGISTRAR'S SIGNATURE J. W. Hedrick

REG. J. W. Hedrick

FUNERAL DIRECTOR

ADDRESS

Jack Lewis Inc 2100 Euclid Ave





RECEIVED  
BUREAU V. S.

FEB 23 1955